

MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

Sample

PERSON REGISTERING THE COMPLAINT

Please Print or Type

☐ Mr. ☐ Ms.

Name: _____
(Last Name) (First Name) (M.I.)

Mailing Address: _____

(City) (State) (Zip)

Phone Number: _____
(Daytime Number) (Evening Number) (Cell phone/E-mail address)

☐ Mr. ☐ Ms.

Patient Name: _____
(Last Name) (First Name) (M.I.)

Patient Date of Birth: _____ **Your Relationship to Patient:** _____

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

☐

Substandard Care (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)

☐

Prescribing Issues (e.g., excessive/under prescribing, Internet)

☐

Unlicensed Provider or Aiding/Abetting unlicensed practice

☐

Sexual Misconduct

☐

Physician/Provider Impairment
(e.g., Drug, Alcohol, Mental, Physical)

☐

Unprofessional Conduct

(e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)

☐

Office Practice (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other _____

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.

I wish to complain about the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one:			
<input type="checkbox"/> Physician (M.D.)	<input type="checkbox"/> Podiatrist (DPM)	<input type="checkbox"/> Physician Assistant (PA)	<input type="checkbox"/> Registered Dispensing Optician (RDO)
		<input type="checkbox"/> Midwife	<input type="checkbox"/> Unlicensed Provider

COMPLAINT REGISTERED AGAINST Please Print or Type

Name: _____
(Last Name) (First Name) (M.I.)

Office/Facility Name: _____ **License No.** (If known):_____

Street Address: _____
(Address) (City) (State) (Zip Code)

Phone Number: () _____

Has the patient been examined/treated by another professional for this same condition?
☐ No ☐ Yes If yes, provide name and address on the Authorization for Release of Medical Information

Reason for Treatment: _____

Date(s) of Treatment: _____

DETAILS OF COMPLAINT
(Attach additional sheets if necessary)



**MEDICAL BOARD OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF
PATIENT HEALTH INFORMATION**

Patient Name: _____

Medical Record No. _____ Date of Birth: _____
(If applicable)

Social Security No.: _____ Date of Death: _____
(Optional) (If applicable)

I, the undersigned hereby authorize: (Please list one Physician or Facility in a separate box)

Physician _____ (Last Name) (First Name) (M.I.) Address _____ Phone Number(s) _____ Treatment Date(s) _____
Physician/Facility _____ Address _____ Phone Number(s) _____ Treatment Date(s) _____
Physician/Facility _____ Address _____ Phone Number(s) _____ Treatment Date(s) _____
Physician/Facility _____ Address _____ Phone Number(s) _____ Treatment Date(s) _____

to provide records in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the **MEDICAL BOARD OF CALIFORNIA, ENFORCEMENT PROGRAM**, a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Medical Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Medical Board of California, 1426 Howe Avenue, Ste. 93, Sacramento, CA, 95825. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____
Patient Date

or _____
Legal Representative Relationship Date

NOTE TO THE PROVIDER: Failure by a physician, podiatrist or health care provider to provide the requested records within 15 days, or health care facility in 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action of the Board. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.